Briefing Paper February 2009
Strengthening Social Protection for Children
reduction of poverty social exclusion security strategy social protection inequality policies
Social Policies
Children's Rights
social protection reaching the MDGs

Children, the PRSP and public expenditure in Sierra Leone

Sierra Leone adopted its first Poverty Reduction Strategy Paper (PRSP) for the period 2005-2007 and has recently adopted a 'second generation' PRSP for the period through to 2012. A study by UNICEF (see box 1) has found that children's interests are well represented in the two PRSPs, as well as in related sector strategies, although further policy development is required to address the financial barriers to accessing health care and education by the poor.

The study also found that public expenditure allocations generally matched PRSP commitments, although spending was limited by constraints on the total resource envelope, particularly in 2007. The health sector bore the brunt of the resource shortfall. Resource constraints also meant that salaries squeezed out spending on other crucial recurrent inputs, leading to inefficiencies in service delivery. Salary spending is also inequitably and inefficiently distributed across the country, rendering some health units non-functional due to a lack of staff. Improvements made in recent years to the public financial management (PFM) system to ensure better linkages between policy and public expenditure will need to be continued so that service delivery for Sierra Leone's children can benefit as fully as possible from future increases in resources.

Box 1. **The study on children, PRSPs and budgets in West and Central Africa**

This is one of eight briefing papers that present the main findings of a study on children, PRSPs and budgets in West and Central Africa. The objective of the study was to deepen understanding of the impact on children of the PRSPs, the evolving fiscal environment and related reforms in public financial management systems and aid modalities in West and Central Africa.

Commissioned by UNICEF's West and Central Africa Regional Office (WCARO) and carried out by Oxford Policy Management (OPM) between November 2007 and February 2009, the study included a regional review and five country case studies on Burkina Faso, Chad, Ghana, Mauritania and Sierra Leone.

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Oxford Policy Management

unicef

Child poverty

Since 2002, Sierra Leone has moved from a phase of post-war recovery and reconstruction to one of development, with considerable improvements in state capability and effectiveness in governance and service delivery. However, it remains one of the poorest countries in the world: 70% of the population lives under the poverty line, with poverty incidence rising to 80% in rural areas and over 90% in several districts.

Child health outcomes are extremely poor. Under-five mortality is 267 per 1,000 live births but this average figure hides wide disparities: in the south the rate is as high as 317. While physical access to health facilities remains a problem in some areas, the most significant barriers are financial. The health system is extremely under-funded, with most resources coming from out-of-pocket payments from patients through a system of user charges. User fees have been abolished for pregnant women and children under the age of five, but implementation has proven problematic, as is recognised in the second PRSP.

Education outcomes have improved markedly in the post-war period, during which time fee-free basic education was introduced. However, wide disparities still remain: the net primary attendance rate for the poorest quintile is only 50%, compared to 90% for the richest. Despite the removal of fees, other costs (exercise books, parent contributions, etc.) remain a significant barrier for many of the poorest households.

PRSP and sector strategies

The first question for the analysis was whether current policy adequately responds to this child poverty situation. Overall the policy framework was found to have a strong pro-poor child focus.

The first generation PRSP was found to focus strongly on children. This included not only a clear prioritization of education and health care services for children, but a broader understanding of the particular nature of child poverty and vulnerability. The second generation PRSP is more heavily tilted towards promoting economic growth than the first PRSP, but human development continues to feature prominently. Innovations in the second PRSP include recognition of the need to address health financing challenges, a commitment to developing a social protection strategy and a range of social protection measures, and a focus on youth employment.

The PRSPs have been complemented by sector strategies. For example, the Education Sector Plan (2007–2015) builds on the PRSPs by including a thorough review of the major challenges to access, equity, quality and completion, and by outlining a series of measures to address both the physical and financial barriers to access.

In health, the guiding policy document is the National Health Policy (2002), with the Reproductive and Child Health Strategy (2008) serving as the main vehicle for donor–government coordination. The overall orientation is towards strengthening primary health care within an integrated three-tier referral system. Financial barriers to access are currently being examined through recent studies on user fees to inform further policy development in this area. The main findings from these studies emphasized the need to address these financial barriers while at the same time ensuring that health units are provided with the essential recurrent inputs needed to maintain an adequate level of quality. In other words, any changes to the user-fee structure must be carried out within the broader context of reform to overall health financing.

Fiscal space

To what extent has public expenditure matched the policy commitments to health and education? And how efficiently and effectively have these funds been used?

Fiscal space for expenditure on children's interests is clearly dependent on the overall level of resources as well as shares of spending. Total real revenue grew steadily from 2002 through 2006, but declined sharply in 2007 due to underperformance in revenue collection and a shortfall in aid. Spending reflected similar patterns, with a significant decrease in real terms in 2007. However, in an effort to improve the fiscal balance, not all the revenue gain over the period from 2002 to 2007 was translated into increased expenditure. As a result, the primary deficit of -3% of GDP in 2002 was converted into a surplus of 1% in 2007.

Box 2. **Aid dependence and budget support**

Sierra Leone's budget is highly dependent on aid, including both grants and loans. Between 1997 and 2001 there was a large increase in real aid flows, most of which was humanitarian relief during the war. Aid has remained fairly constant since 2003 at about US$350 million per year (in constant 2006 prices), with debt relief providing only a small percentage of aid. The vast majority of aid is in the form of project support to individual ministries, departments and agencies, often through separate project implementation units.

However, general budget support (GBS) increased substantially from 2001 to 2006, doubling from 12% to 24% of total expenditure and net lending. This is a significant level of GBS, comparable to countries such as Rwanda, Tanzania and Uganda that have more 'mature' PFM systems. As a result, Sierra Leone is highly sensitive to the unpredictability of GBS disbursements. In 2004 and 2005, delays in the disbursement of GBS 'performance tranches' meant that the government had to resort to expensive domestic borrowing to cover the shortfalls.

Social sector expenditure

Between 2004 and 2007, there was a real contraction of 6.1% in total expenditure. Social sector spending contracted more, by 7.3%, while spending increased on economic services (2.4%) and general services (5.5%). The social sectors were therefore particularly badly hit. Education seems to have fared relatively well, while health bore the brunt of the squeeze. Health had zero development (investment) expenditure in 2007, and also faced significant reductions in recurrent expenditure (see Figure 1), affecting particularly non-salary recurrent spending and the ability of health facilities to deliver services.

What do these trends mean in terms of the real level of resources available to the social sectors? Total real spending on education increased by 5% between 2004 and 2007, but health spending fell by 33% over the same period, although this did follow an 11% increase between 2004 and 2006. Spending in health and education picked up in 2008 and is expected to continue to do so. Health spending in particular is budgeted to increase in 2009, so that real growth over the 2005-2009 period is expected to be 46% in health compared to 28% in education. This will hopefully redress the under-funding in the health sector.

For a breakdown of spending within sectors there were no available actual historical data. However, it is of some concern that forward-looking estimates in education predict a decreasing share for primary in favour of increased allocations to tertiary spending between 2007 and 2009, with a similar pattern in health spending where secondary and tertiary facilities are prioritized over primary facilities.

Efficiency and equity of spending

Most striking of all has been the composition of spending across economic categories. At an aggregate level, salaries expanded from 22% to 35% of total spending between 2002 and 2007, with a marked increase in 2007. In the face of the revenue shortfall, salaries were prioritized over other spending. This affected health and education, where salary spending squeezed out other recurrent inputs, with serious implications for the efficiency of service delivery in both these sectors, as spending on essential complementary inputs, such as drugs and other supplies, was compromised. Worryingly, in education, the salary increases were concentrated in secondary and tertiary education rather than primary education. This may be offset to some extent by donors, who do not fund salaries but often supply complementary inputs such as drugs or textbooks. Nonetheless, there are insufficient levels of non-salary inputs.

Unfortunately, geographically disaggregated budget data are unavailable. However, it is possible to draw some conclusions on geographic equity by analysing the distribution of personnel and facilities. There are clear geographic disparities in staff/population ratios. The numbers of doctors and Community Health Officers

(CHOs) increased across most districts aside from Bonthe, Moyamba and Koinadugu, but this did little to improve the geographic balance. By contrast, in the nursing, midwife and MCH Aide categories, there were high levels of attrition, with some districts (Koinadugu for example) much more affected than others and Western Area bearing little of the impact.

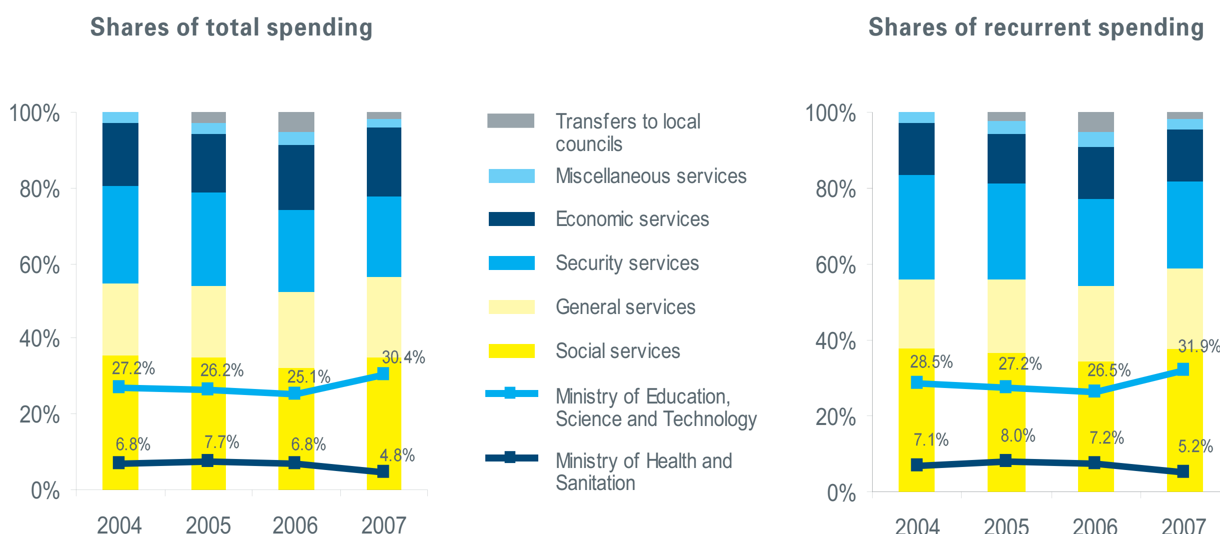
Human resources are also allocated inefficiently across health units. Apart from Western Area, all other districts have less than two qualified staff per facility on average, with some having only one. There are 19 units across the primary level without any staff at all. This suggests that health units are not operating at optimal levels. Furthermore, non-salary recurrent costs are funded almost exclusively from user fees generated by the health units.

To address the staffing imbalances, measures have been taken to offer a bonus to workers in deprived areas. However, the incentive is very small (10% of salary) and in general the centralized control of staffing makes management by the Ministry of Health and Sanitation or local councils difficult. Currently line ministries are unable to easily access payroll information, making it difficult to plan, budget or manage staff.

A public expenditure review in the health sector found that in general productivity is low in terms of bed occupancy and throughput. In some cases, facilities were found to be almost empty, with the notable exception of referral hospitals in Freetown reporting high occupancy levels. Facilities are also chronically undersupplied: for example, the Connaught hospital in Freetown, which is the main referral hospital, does not have running water. The low occupancy rates overall give rise to high unit costs.

In education, the distribution of teachers per capita is skewed, with Kono particularly disadvantaged. There also appear to be wide variations in the ratio of qualified teachers to total teachers. A 2006 survey provides revealing information on the non-functioning of some schools and wide disparities in the availability of school equipment and textbooks. Roughly 3% of schools were found to be closed, reaching 7% in Pujehun. Bombali showed the highest pupil/desk ratio at 5.2 students per desk, and Koidu town showed a figure of 10.2 pupils per book . Given these wide disparities, there would appear to be some room to allocate resources more equitably and efficiently across the country.

Figure 1. **Distribution of spending across sectors, 2004-2007**



Source: Audited government accounts, 2004-2007.

Underlying PFM weaknesses

The inefficiencies and disparities highlighted above partly reflect problems in the PFM system itself, at different stages of the budget cycle (see Figure 2).

The following are the four most important problems, from the perspective of service delivery in health and education.

First, poor budget credibility and unpredictability of funds lower the line ministries' incentives to engage fully in the budget process and compromise the efficiency of service delivery. While the causes are related to poor revenue performance and the unpredictability of donor funding, improvements in the budget process could be made to ensure that priority social sectors are protected from expenditure cutbacks and delays in disbursements.

Second, off-budget and fragmented project aid lead to the inefficient allocation of resources, for example when donor or community projects funded through the National Commission for Social Action construct new health units that are not then staffed or provided with recurrent inputs. In the health sector there are roughly 75 different funding sources for the construction of primary health facilities and 45 for the provision of equipment. Aside from the difficulties caused by this fragmentation, it also reduces the incentives for line ministries to produce detailed MTEF and budget submissions, as Ministry of Finance funds are only a small part of the total and among the most unpredictable.

Third, lack of true decentralized control has meant that districts and line ministries are unable to execute their budgets effectively. For example, in education, textbooks were until recently delivered from the centre directly to schools, bypassing the district entirely. This has now been addressed, but it highlights the importance of ensuring that budget holders are given responsibility for execution.

Fourth, lack of budget reporting on financial and physical execution severely limits the ability to hold managers (at district or line ministry level) to account for performance. This then further weakens incentives for producing thorough budget submissions in the following year.

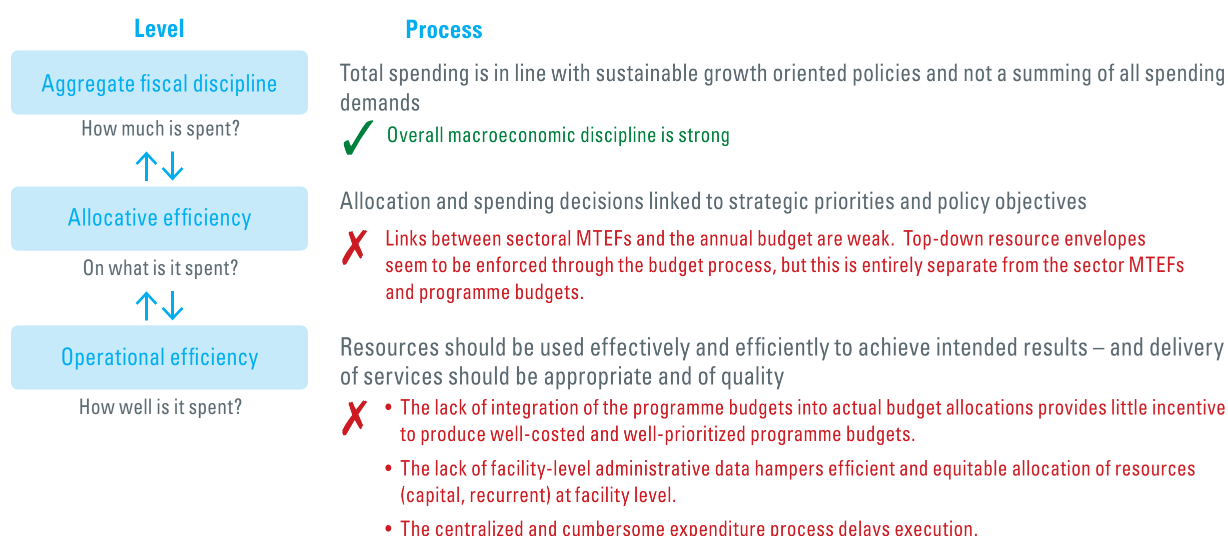
Recommendations

Based on the findings, the study concludes with several recommendations regarding policy formulation, resource allocation, PFM and aid effectiveness.

Policy

The key recommendation here is to address the remaining issues with respect to health financing, in order to reduce financial barriers to access and improve the quality of

Figure 2. **Overall PFM performance**



service provision. The new PRSP recognises this need and proposes a National Social Health Insurance Scheme, while noting the challenges of financing such a scheme. In order to ensure that equity and quality of service provision are adequately addressed, we recommend further diagnostic work to better understand the impact of changes in user fees or insurance schemes on both the uptake of care by the poor and the supply of quality services. Institutional capacity may need to be built within the Ministry of Health and Sanitation to ensure there are qualified staff to address these health financing issues.

Public expenditure

Further attention should be given to the degree of prioritization of the social sectors, in particular health, within the total and recurrent budgets. The allocations across education sub-sectors should also be reviewed to ensure spending on tertiary education does not come at the expense of primary education. In all the social sectors, the composition of expenditure across salaries, goods and services, and development must be carefully balanced to ensure adequate levels of complementary inputs are provided.

Improving PFM for service delivery

Achieving these changes in public expenditure will require changes to the PFM system to ensure that resources are effectively targeted towards child poverty reduction and are spent in an equitable and efficient manner. The key recommendations include the following.

- Improve budget credibility by providing clear indications to districts and line ministries of budget ceilings early in the year and ensuring the predictability of funding through more accurate revenue forecasting and mechanisms to ensure that social sector spending is protected in the face of revenue shortfalls.
- Devolve budget control to line ministries and districts within ceilings, including responsibilities for budget execution and human resource management.
- Improve links between policies, the MTEF and the annual budget by ensuring consistency in the budget classification, expanding the financial management information system and reinforcing its use in reporting, and building capacity in line ministries to prepare MTEF/budget submissions and in the Ministry of Finance to review them.
- Strengthen accountability mechanisms through reporting on physical and financial budget execution. This should include reporting from the line ministries to the Ministry of Finance, as well as from districts to the Ministry of Finance and to line ministries. The focus should be, at least initially, on a few key simple measures of outputs rather than on outcome indicators.

Aid effectiveness

Development partners should focus efforts to ensure that there is greater predictability of aid and that the social sectors are not adversely impacted when shortfalls in budget support do occur. This will involve better coordination and harmonization to ensure that the performance assessment framework for budget support takes adequate consideration of objectives in the social sectors. Development partners also have a large role to play in strengthening country systems by ensuring resources are 'on plan' and reducing the vertical nature of funding, especially direct support at district levels.

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